

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13A012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/29/2025
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NAME OF PROVIDER OR SUPPLIER ARBOR TERRACE MORRIS PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 361 SPEEDWELL AVENUE MORRIS PLAINS, NJ 07950
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ188493 CENSUS: 83 SAMPLE SIZE: 3 SURVEY DATE: 10/27/2025 - 10/29/2025</p> <p>The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, based on this Complaint Survey.</p> <p>The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A 389	<p>8:36-4.1(a)(16) Resident Rights</p> <p>(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:</p> <p>16. The right to be free from physical and mental abuse and/or neglect;</p> <p>This REQUIREMENT is not met as evidenced</p>	A 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/22/25

New Jersey Department of Health

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A 389	<p>Continued From page 1</p> <p>by: NJ188493</p> <p>Based on interview, record review, and facility document and policy review, the facility failed to ensure supervision was provided to prevent [redacted] for 1 (Resident #1) of 3 residents reviewed for [redacted] Resident #1 [redacted] from the facility on [redacted] without staff knowledge.</p> <p>It was determined that the facility's non-compliance with one or more requirements had caused or was likely to cause serious injury, harm, impairment, or death to residents.</p> <p>On 10/28/2025, the New Jersey Department of Health determined the failed practice represented an imminent danger to residents' health and safety. The facility's Executive Director (ED) was informed of the imminent danger on [redacted] at 5:40 PM.</p> <p>Findings included:</p> <p>Review of a facility policy titled, "Resident Security Response Plan," with a review date of 07/2025, revealed, "Any time a Resident is found in an unsafe location (relative to each Resident's safety awareness and abilities), staff will respond according to company protocols in order to promote Resident safety."</p> <p>Resident #1's facesheet indicated the resident's physical move-in date was [redacted]. According to the facesheet, the resident had primary medical diagnoses that included [redacted]</p>	A 389		
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A 389	<p>Continued From page 2</p> <p>A "Physician's Assessment" completed on [redacted] indicated Resident #1 had [redacted] and [redacted]. The assessment indicated Resident #1's [redacted] did not necessitate a [redacted] unit where the resident could not [redacted] NJ Exec Order 26.4b1. The assessment noted the resident [redacted] NJ Exec Order 26.4b1, had [redacted] NJ Exec Order 26.4b1, could [redacted] NJ Exec Order 26.4b1 their [redacted] NJ Exec Order 26.4b1 and was appropriate for an assisted living community. On page four of the assessment there was a prompt for reasons the resident was not recommended for the assisted living residency, where it was documented that the resident was [redacted] NJ Exec Order 26.4b1, but [redacted] NJ Exec Order 26.4b1." The assessment was completed 11 days prior to Resident #1's admission to the facility.</p> <p>An "Initial Assessment," dated [redacted] NJ Exec Order 26.4b1, indicated Resident #1 was at risk for [redacted] NJ Exec Order 26.4b1 and could only [redacted] NJ Exec Order 26.4b1 with staff, family, or a friend. The assessment was conducted five days prior to Resident #1's admission to the facility.</p> <p>A "[redacted] NJ Exec Order 26.4b1 Examination," dated [redacted] NJ Exec Order 26.4b1, indicated Resident #1 scored a [redacted] NJ Exec Order 26.4b1 indicating [redacted] NJ Exec Order 26.4b1.</p> <p>A "Care Plan," last updated on [redacted] NJ Exec Order 26.4b1 indicated the resident had [redacted] NJ Exec Order 26.4b1. There was no documentation of the [redacted] NJ Exec Order 26.4b1 score on the care plan. There were no interventions in place to address the late-day confusion documented by the physician in the aforementioned "Physician's Assessment."</p> <p>An incident report summary, dated [redacted] NJ Exec Order 26.4b1</p>	A 389		
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A 389	<p>Continued From page 3</p> <p>indicated Resident #1 entered the facility lobby around 2:15 PM to sit outside on the facility's front porch. The resident stopped at the front door, then came back to give a Concierge the resident's jacket, stating, "NJ Exec Order 26.4b1." The Concierge observed the resident walk to the porch and sit in a rocking chair. At 2:40 PM, a NJ Exec Order 26.4b1 brought Resident #1 NJ Exec Order 26.4b1. The manager on duty (MOD) spoke with the officer. The officer explained that Resident #1 NJ Exec Order 26.4b1 and said Resident #1 was NJ Exec Order 26.4b1. The NJ Exec Order on duty discovered the resident had their license on them, and stuck to the back of the license was a note with the facility address. At 2:50 PM, the MOD notified the Resident Care Director (RCD) and the ED was then added to the call. The RCD arrived at the facility and applied a NJ Exec Order 26.4b1 to the resident. Staff were informed to NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1. The resident's family member was notified that the resident would require a NJ Exec Order 26.4b1 environment. Review of a staff statement within the investigative packet, dated NJ Exec Order 26.4b1 revealed the staff member had noticed changes in Resident #1 recently, specifically that the resident was NJ Exec Order 26.4b1.</p> <p>On 10/27/2025 at 2:21 PM, a Concierge stated that, at the time of the NJ Exec Order 26.4b1 Resident #1 was new to the facility. She stated that the day of the NJ Exec Order 26.4b1 was the first time she had seen Resident #1. Resident #1 asked her to hold their NJ Exec Order 26.4b1. She stated Resident #1 was a resident who was NJ Exec Order 26.4b1. She stated her last interaction with the resident occurred around 2:20 PM (on NJ Exec Order 26.4b1), noting</p>	A 389		
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A 389	<p>Continued From page 4</p> <p>she did not see the resident [redacted] NJ Exec Order 26.4b1 [redacted]. The Concierge stated that, after the resident handed her the coat, she saw the resident sit in a rocking chair, noting that was the last time she saw the resident until the [redacted] NJ Exec Order 26.4b1 [redacted] around 2:45 PM while [redacted] NJ Exec Order 26.4b1 [redacted] the resident [redacted] NJ Exec Order 26.4b1 [redacted].</p> <p>On 10/29/2025 at 8:20 AM, during a follow-up interview, the Concierge stated she always kept an eye on the facility's patio. She stated there was a list of residents who were [redacted] NJ Exec Order 26.4b1 [redacted], and the list was kept at the front desk. She stated Resident #1 was not on the front desk list at the time of Resident #1's [redacted] NJ Exec Order 26.4b1 [redacted]. She stated she was not aware of the process to notify staff if a resident was on the patio. She stated residents were allowed to go to the patio and sit outside if they lived on the second floor.</p> <p>On 10/27/2025 at 12:02 PM, Resident Assistant (RA) #1 stated Resident #1 had experienced some [redacted] NJ Exec Order 26.4b1 [redacted]. Per RA #1, Resident #1 lived in a [redacted] NJ Exec Order 26.4b1 [redacted]. She stated Resident #1 was known to [redacted] NJ Exec Order 26.4b1 [redacted]. She stated that, on the day of Resident #1's [redacted] NJ Exec Order 26.4b1 [redacted] around 2:00 PM, Resident #1 asked RA #1 if the resident had eaten lunch, noting she told the resident they had already eaten. She then provided the resident with a snack. She stated the resident went back to their room. She stated she did not observe the resident [redacted] NJ Exec Order 26.4b1 [redacted] after the resident went to their room.</p> <p>On 10/27/2025 at 3:14 PM, a Medication Technician stated Resident #1 normally went [redacted] NJ Exec Order 26.4b1 [redacted] and would then come [redacted] NJ Exec Order 26.4b1 [redacted]. She stated there was an incident when Resident #1 [redacted] NJ Exec Order 26.4b1 [redacted] on</p>	A 389		
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A 389	<p>Continued From page 5</p> <p>NJ Exec Order 26.4b1. She stated that, around 2:00 PM that day, Resident #1 stated they had not eaten lunch. She stated staff provided the resident with another lunch, and after they had eaten the lunch, they went back to their room and sat in their NJ Exec Order 26.4. She stated she did not see the resident go downstairs. She stated she thought the resident was in their room where she left the resident.</p> <p>On 10/28/2025 at 5:06 PM, the ED stated a physician determined if a resident was appropriate for assisted living (AL) placement. The ED stated a nurse conducted a full assessment, including a NJ Exec Order 26.4 examination, and based on input from family and information from a receiving facility, the neighborhood in which the resident might live was identified, after which a physician conducted an assessment. If the physician agreed with the proposed neighborhood, then the physician admitted the resident to that neighborhood. She stated if a resident was having NJ Exec Order 26.4b1 concerns or a NJ Exec Order 26.4b1, a nurse conducted a reassessment. She noted that facility care staff were mindful to report increased confusion for a resident. Per the ED, if NJ Exec Order 26.4b1 was identified, staff called the physician and received physician orders to attempt to determine the etiology of the NJ Exec Order 26.4b1. She stated if it was determined a resident was not safe to stay in the neighborhood, staff called the family and physician and recommended moving to a secure unit or, if a NJ Exec Order 26.4b1 apartment was unavailable, a NJ Exec Order 26.4b1 was placed on the resident based on NJ Exec Order 26.4b1 and the facility could request the family provide a NJ Exec Order 26.4b1 while the facility worked on appropriate placement. She stated that, if the family declined the move, they would ask the family to provide a private duty</p>	A 389		
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A 389	<p>Continued From page 6</p> <p>NJ Exec Order 26.4b1 caregiver at the family's expense. The ED stated that, in the NJ Exec Order 26.4b1 the residents were admitted with a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and with the ability to use a NJ Exec Order 26.4b1.</p> <p>On 10/28/2025 at 8:50 AM, the RCD stated she conducted admission assessments of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 according to company policy to determine the safety of an admission and placement within the facility, noting if the assessment was conducted by the NJ Exec Order 26.4b1 director, she reviewed and signed it. She stated if a resident was admitted to the NJ Exec Order 26.4b1, the resident had NJ Exec Order 26.4b1. She stated a resident could have NJ Exec Order 26.4b1 and still live on the NJ Exec Order 26.4b1 if they did not NJ Exec Order 26.4b1 or have NJ Exec Order 26.4b1, which she noted would be a safety issue. She stated that once an admission was complete, staff conducted a reassessment within 30 days or as needed to ensure safety, including how the resident was acclimating to the environment and whether any changes had occurred. She stated Resident #1 attended activities and meals, noting Resident #1 had NJ Exec Order 26.4b1 or exhibited signs of NJ Exec Order 26.4b1. She stated that, on NJ Exec Order 26.4b1 (a Sunday) at 2:50 PM, she was called about Resident #1's NJ Exec Order 26.4b1 and was told the resident walked to a NJ Exec Order 26.4b1. She stated she went to the facility, assessed the resident, and called the ED. She stated if a resident had NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 of the facility was appropriate placement, depending on the resident's NJ Exec Order 26.4b1 noting that NJ Exec Order 26.4b1 indicating a risk for NJ Exec Order 26.4b1 the facility would prompt placement in NJ Exec Order 26.4b1. She stated if a resident had NJ Exec Order 26.4b1, " such as NJ Exec Order 26.4b1, then the facility</p>	A 389		
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A 389	<p>Continued From page 7</p> <p>maintained the resident's placement on the [redacted], unless there were any indications a resident needed to be in the [redacted] unit. She stated if a resident's [redacted] or [redacted] changed, staff would notify the physician and family and move the resident to the [redacted] unit.</p> <p>On 10/28/2025 at 2:20 PM, the ED stated Resident #1's physician assessment indicated Resident #1 did not require a [redacted], noting the resident was certified to live in an AL facility. She stated that, although the assessment noted Resident #1 had [redacted] the resident was not [redacted]. She stated it was incumbent upon facility staff to observe/assess if [redacted] was occurring. She stated interventions for [redacted] were addressed in the moment, noting the intervention could simply be [redacted] the resident. She stated the goal of the unit was to honor a resident's [redacted]. She stated residents [redacted], but [redacted]. Per the ED, residents on the [redacted] were observed more frequently. She stated if anyone was out on the porch, the concierge would know and facility staff, including the concierge, would let nursing staff know if a [redacted] unit resident was on the porch. She stated staff were assigned residents and were to be aware of their residents' [redacted] at all times, noting a shift change [redacted] was conducted and that attendance was taken in all dining rooms, with a radio system utilized if a resident [redacted] their dining room. Per the ED, staff conducted assignment checks every 30-45 minutes, stating there was programming every 30 minutes. She stated if a resident decided to do something different, staff would know they were [redacted].</p>	A 389		
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A 389	<p>Continued From page 8</p> <p>On 10/28/2025 at 1:48 PM, the Memory Care Program Director (MCPD) stated that either she, the RCD, or the ED reviewed physician assessments to determine if a resident was safe for an AL facility. She stated that before staff received the physician assessment, the facility had generally already conducted an initial resident assessment and determined an appropriate neighborhood for the resident, noting a reassessment was conducted in 30 days or as needed. She stated that, when she assessed Resident #1, the resident was not showing more NJ Exec Order 26.4b1 or exhibiting other signs of NJ Exec Order 26.4b1. She stated the physician assessment was factored into the resident being considered for the NJ Exec Order 26.4b1, noting it was identified that Resident #1 was NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1. She stated NJ Exec Order 26.4b1 was not on Resident #1's care plan, and there were no interventions in place for NJ Exec Order 26.4b1. She stated residents from the NJ Exec Order 26.4b1 were able to NJ Exec Order 26.4b1 upstairs, noting staff were educated to NJ Exec Order 26.4b1 and the NJ Exec Order of NJ Exec Order a resident was NJ Exec Order 26.4b1 including the front desk concierge, who was to alert staff if a resident was NJ Exec Order 26.4b1. She denied that residents who should not be NJ Exec Order 26.4b1, noting that second floor staff were aware daily of which residents were not participating in activities or at a meal service.</p> <p>On 10/28/2025 at 5:55 PM, a NJ Exec Order 26.4b1 stated the NJ Exec Order 26.4b1 had a lobby containing a phone. He stated Resident #1 entered the lobby and picked up the phone, noting it rang their dispatch staff. He stated Resident #1 asked for</p>	A 389		
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A 389	<p>Continued From page 9</p> <p>NJ Exec Order 26.4b1. He stated the resident NJ Exec Order 26.4b1. He stated Resident #1 described NJ Ex Order 26.4(b)(1) but NJ Exec Order 26.4b1 where they were NJ Exec Order 26.4b1. He stated he checked the resident's wallet, which contained a note with the facility address. He stated he gave Resident #1 a NJ Exec Order 26.4b1 to the facility, and facility staff identified the resident.</p> <p>On 10/29/2025 at 9:21 AM, a Physician Assistant Certified (PAC) stated Resident #1 resided in NJ Exec Order 26.4b1 when the PAC evaluated the resident, noting he signed off that the resident was appropriate for a facility with more NJ Exec Order 26.4b1 residents with NJ Exec Order 26.4b1 as discussed with a family member. He stated Resident #1 was transitioned out of NJ Exec Order 26.4b1 because it was NJ Exec Order 26.4b1. The PAC confirmed that Resident #1 was NJ Exec Order 26.4b1 noting the NJ Exec Order 26.4b1 identified in his examination would impact Resident #1's NJ Exec Order 26.4b1, though he noted that NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. He identified that the facility should be able to assess which unit a resident needed. He stated that, at the time Resident #1 NJ Exec Order 26.4b1 from the facility, he believed the resident was NJ Exec Order 26.4b1 noting he believed at the time of his evaluation of Resident #1 that the resident would have been safe to sit out on the facility's NJ Exec Order 26.4b1.</p>	A 389		
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POC#2 received 1/12/26
Accepted 1/12/26

361 Speedwell Avenue
Morris Plains, NJ 07950
973-718-3636



ARBOR TERRACE
morris plains

the *New Signature*
of senior living

Plan of Correction for 10/29/2025

Received 12/8/2025.

A389-Completed 12/19/2025.

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice?

For Resident # 1- on ^{NJ Exec Order 26.4b} ^{NJ Exec Order 26.4b1} placed on resident- as well as ^{NJ Exec Order 26.4b1} with Residents name- name of the community, address of the community and phone number of the community ^{NJ Exec Order 26.4b1} Plan of Care- MAR and observation notes updated with information for ^{NJ Exec Order 26.4b1} Resident moved to ^{NJ Exec Order 26.4b1} care neighborhood ^{NJ Exec Order 26.4b1} with information remains in place.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice?

All residents are potential to be an elopement risk and are at risk for this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

Additional wristbands were placed in the Wellness Center in Evergreen and Bridges neighborhoods in September 2025 they were ordered end of August 2025. Wander guard system is in place. To continue to prevent future elopements in the future these items are readily available. The Nurse or lead CMA on duty will be responsible to provide wristband with resident name- community name, community address and phone number and wander guard as initial intervention. This will be documented in the residents record that wristband and Wander guard were placed. This will also be placed on the MAR for each shift to check for wristband placement as well as wander guard check. If the wristband is lost or Wander guard is not functioning properly it will be replaced. Staff training was provided for all 3 shifts on



361 Speedwell Avenue
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10/30/25 and 10/31/2025 regarding these interventions as well as a review of the elopement policy. Education provided by Executive Director who is an RN and the New Signature of senior living

ARBOR TERRACE

Resident Care Director who is an RN. Yearly elopement Drills will continue and yearly training to all staff in all departments on elopement risks and interventions.

- 4. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes?**

The MCD- Memory Care Director and the RCD- Resident Care Director will ensure during monthly wellness checks that wristbands are secure, clean, and legible. They will check MARS weekly for compliance that staff are checking wristbands and wander guards per shift. Daily standup meetings will include reviewing who has a wristband on and that wander guards are in place and working.

Completion Date – October 31st, 2025

NJ Exec Order 26.4b1

Submitted – 12.19.2025

Approved 1/12/20

NJ Exec Order 26.4b1

RN, CALA

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 13A012	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/12/2026
NAME OF FACILITY ARBOR TERRACE MORRIS PLAINS		STREET ADDRESS, CITY, STATE, ZIP CODE 361 SPEEDWELL AVENUE MORRIS PLAINS, NJ 07950

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0389	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/31/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/29/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		